FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039834

Facility Name: Jackson Square Nrsg & Rehab

Address: 5130 W Jackson Blvd (Number) Chicago (City) 60644 (Zip Code)

County: Cook

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

IDPA ID Number: 363961688001

Date of Initial License for Current Owners: 07/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	234	TOTALS	234	85,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	66,329	1,943	7,802	76,074	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,329	1,943	7,802	76,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.07%

D. How many bed-hold days during this year were paid by Public Aid? 1,436 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 66 and days of care provided 6,449

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	270,747	90,161	20,764	381,672		381,672		381,672			1
2	Food Purchase		354,562		354,562	(17,706)	336,856	(91)	336,765			2
3	Housekeeping		42,344	343,213	385,557		385,557		385,557			3
4	Laundry		31,945		31,945		31,945		31,945			4
5	Heat and Other Utilities			260,842	260,842		260,842	(10,657)	250,185			5
6	Maintenance	91,216	29,121	156,583	276,920		276,920	(21,804)	255,116			6
7	Other (specify):*							(33)	(33)			7
8	**TOTAL General Services**	361,963	548,133	781,402	1,691,498	(17,706)	1,673,792	(32,585)	1,641,207			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,578,180	173,288	9,840	2,761,308		2,761,308	(4,731)	2,756,577			10
10a	Therapy	91,494		9,516	101,010		101,010		101,010			10a
11	Activities	88,982	5,124	2,504	96,610		96,610		96,610			11
12	Social Services	79,637		2,716	82,353		82,353		82,353			12
13	Nurse Aide Training											13
14	Program Transportation			1,665	1,665		1,665	2	1,667			14
15	Other (specify):*							20	20			15
16	**TOTAL Health Care and Programs**	2,838,293	178,412	47,841	3,064,546		3,064,546	(4,709)	3,059,837			16
	C. General Administration											
17	Administrative	138,788		627,315	766,103		766,103	(554,088)	212,015			17
18	Directors Fees											18
19	Professional Services			79,459	79,459		79,459	(2,680)	76,779			19
20	Dues, Fees, Subscriptions & Promotions			67,282	67,282		67,282	(36,363)	30,919			20
21	Clerical & General Office Expenses	161,041	30,390	164,641	356,072		356,072	5,692	361,764			21
22	Employee Benefits & Payroll Taxes			571,504	571,504	17,706	589,210		589,210			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,540	4,540		4,540	(919)	3,621			24
25	Other Admin. Staff Transportation			1,741	1,741		1,741	251	1,992			25
26	Insurance-Prop.Liab.Malpractice			276,323	276,323		276,323	520	276,843			26
27	Other (specify):*							35,446	35,446			27
28	**TOTAL General Administration**	299,829	30,390	1,792,805	2,123,024	17,706	2,140,730	(552,141)	1,588,589			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,500,085	756,935	2,622,048	6,879,068		6,879,068	(589,435)	6,289,633			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jackson Square Nrsg & Rehab #0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			144,689	144,689		144,689	99,160	243,849			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,030	38,030		38,030	823,348	861,378			32
33	Real Estate Taxes			338,706	338,706		338,706	(25,111)	313,595			33
34	Rent-Facility & Grounds			1,495,964	1,495,964		1,495,964	(1,483,996)	11,968			34
35	Rent-Equipment & Vehicles			13,724	13,724		13,724	7,664	21,388			35
36	Other (specify):*											36
37	TOTAL Ownership			2,031,113	2,031,113		2,031,113	(578,935)	1,452,178			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	12,184	134,223	485,655	632,062		632,062	(74)	631,988			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,115	128,115		128,115		128,115			42
43	Other (specify):*	52,761			52,761		52,761	(52,761)				43
44	TOTAL Special Cost Centers	64,945	134,223	613,770	812,938		812,938	(52,835)	760,103			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,565,030	891,158	5,266,931	9,723,119		9,723,119	(1,221,205)	8,501,914			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	97,384	30		9
10	Interest and Other Investment Income	(10)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(91)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(900)	21		18
19	Entertainment				19
20	Contributions	(13,901)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	21		24
25	Fund Raising, Advertising and Promotional	(17,321)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,995)	20		28
29	Other-Attach Schedule	(166,752)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (200,585)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,020,619)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,020,619)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,221,205)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Jackson Square Nrsg & Rehab

IDF 0039834

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL Council on LTC - COPE Dues	$ (3,366)	20	1
2	Bank Charges	(20,893)	21	2
3	Part B Coinsurance Write Offs - Therapy	(17,936)	21	3
4	Veterans Pharmacy	(4,067)	10	4
5	Travel & Entertainment	(887)	24	5
6	Marketing Expense	(844)	19	6
7	Non-Care Asset Depreciation	(1,254)	30	7
8	Marketing Salary	(52,761)	43	8
9	Capitalized R&M	(23,596)	06	9
10	Non Allowable Legal	(3,360)	19	10
11	Veterans Medical Expenses	(845)	10	11
12	Non-Allowable Seminar	(783)	24	12
13	Clinic Allocation - Real Estate Tax	(25,111)	33	13
14	Clinic Allocation - Utilities	(11,049)	05	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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100				100
101	**Total**	(166,752)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(91)											(91)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,049)		392									(10,657)	5
6	Maintenance	(23,596)		1,792									(21,804)	6
7	Other (specify):*			(33)									(33)	7
8	**TOTAL General Services**	(34,736)		2,151									(32,585)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,912)		181									(4,731)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			2									2	14
15	Other (specify):*			20									20	15
16	**TOTAL Health Care and Programs**	(4,912)		203									(4,709)	16
	C. General Administration													
17	Administrative			23,450	(575,307)	(2,231)							(554,088)	17
18	Directors Fees													18
19	Professional Services	(4,204)		1,473		51							(2,680)	19
20	Fees, Subscriptions & Promotions	(37,583)		1,317		(97)							(36,363)	20
21	Clerical & General Office Expenses	(135,729)		140,697		724							5,692	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(1,670)		728		23							(919)	24
25	Other Admin. Staff Transportation			251									251	25
26	Insurance-Prop.Liab.Malpractice			520									520	26
27	Other (specify):*			30,769	2,988	1,689							35,446	27
28	**TOTAL General Administration**	(179,186)		199,205	(572,319)	159							(552,141)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(218,834)		201,559	(572,319)	159							(589,435)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	96,130		3,029									99,160	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(10)	824,183	(817)		(8)							823,348	32
33	Real Estate Taxes	(25,111)											(25,111)	33
34	Rent-Facility & Grounds		(1,495,964)	11,968									(1,483,996)	34
35	Rent-Equipment & Vehicles			7,664									7,664	35
36	Other (specify):*													36
37	**TOTAL Ownership**	71,009	(671,781)	21,844		(8)							(578,935)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(74)									(74)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(52,761)											(52,761)	43
44	**TOTAL Special Cost Centers**	(52,761)		(74)									(52,835)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(200,585)	(671,781)	223,329	(572,319)	151							(1,221,205)	45

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 1,495,964	Jackson Square Associates		$	$ (1,495,964)	1
2	V		32	Interest Expense		Jackson Square Associates		825,320	825,320	2
3	V		32	Interest Income	1,137	Jackson Square Associates			(1,137)	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 1,497,101			$ 825,320	$ * (671,781)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 392	$ 392	15
16	V	6	REPAIRS AND MAINT.				1,792	1,792	16
17	V	7	EMPLOYEE BEN. GEN. SERV.				(33)	(33)	17
18	V	10	NURSING ADMIN.				181	181	18
19	V	14	PROGRAM TRANSPORTATION				2	2	19
20	V	15	HEALTHCARE EMPLOYEE BEN.				20	20	20
21	V	17	ADMINISTRATIVE - NON-OWNER				23,450	23,450	21
22	V	19	PROFESSIONAL FEES				1,473	1,473	22
23	V	20	FEES SUBSCRIPTIONS				1,317	1,317	23
24	V	21	CLERICAL & GENERAL				140,697	140,697	24
25	V	24	SEMINARS AND EDUCATION				728	728	25
26	V	25	ADMIN. STAFF TRAVEL				251	251	26
27	V	26	INSURANCE				520	520	27
28	V	27	EMPLOYEE BEN. GEN. ADMIN.				30,769	30,769	28
29	V	30	DEPRECIATION				3,029	3,029	29
30	V	32	INTEREST EXPENSE				(817)	(817)	30
31	V	34	BUILDING RENT				11,968	11,968	31
32	V	35	EQUIPMENT RENTAL				7,664	7,664	32
33	V	39	ANCILLARY				(74)	(74)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 223,329	$ * 223,329	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 20,360	$ 20,360	15
16	V		17	ADMIN. - B. CARR				16,715	16,715	16
17	V		17	ADMIN. - D. HARTMAN				4,570	4,570	17
18	V		17	ADMIN. - E. DICKMAN				388	388	18
19	V									19
20	V		27	EMP. BEN. - R. HARTMAN				1,803	1,803	20
21	V		27	EMP. BEN. - B. CARR				796	796	21
22	V		27	EMP. BEN. - D. HARTMAN				357	357	22
23	V		27	EMP. BEN. - E. DICKMAN				32	32	23
24	V									24
25	V									25
26	V		17	MANAGEMENT FEES	617,340				(617,340)	26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 617,340			$ 45,021	$ * (572,319)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 7,744	$ 7,744	15
16	V	19	PROFESSIONAL FEES				51	51	16
17	V	20	FEES, SUBSCRIPTIONS				(97)	(97)	17
18	V	21	CLERICAL AND GENERAL				724	724	18
19	V	24	SEMINARS				23	23	19
20	V	27	GEN ADMIN.- EMP. BEN.				1,689	1,689	20
21	V	32	INTEREST EXPENSE				(8)	(8)	21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	9,975				(9,975)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,975			$ 10,126	$ * 151	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	WORKMANS COMPENSATION	$ 67,360	DIAMOND INSURANCE	40.00%	$ 67,360	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 67,360			$ 67,360	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Robert Hartman	Owner	Administrative	60.75%	See Attached	4.04	8.08%	Alloc-Nucare	$ 20,360	17-7	1
2	Barry Carr	Owner	Administrative	4.75%	See Attached	4.41	7.35%	Alloc-Nucare	16,715	17-7	2
3	David Hartman	Relative	Administrative		See Attached	0.90	1.88%	Alloc-Nucare	4,570	17-7	3
4	Eitan Dickman	Relative	Administrative		See Attached	0.38	0.88%	Alloc-Nucare	388	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 42,033		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	755,108	9	$ 3,469	$	85,410	$ 392	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	755,108	9	15,840	(985)	85,410	1,792	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	755,108	9	(289)		85,410	(33)	3
4	10	NURSING ADMIN.	AVAIL. CENSUS DAYS	755,108	9	1,600	1,600	85,410	181	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	755,108	9	19		85,410	2	5
6	15	HEALTHCARE EMPLOYEE BE	AVAIL. CENSUS DAYS	755,108	9	180		85,410	20	6
7	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	755,108	9	207,317	202,582	85,410	23,450	7
8	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	755,108	9	13,022		85,410	1,473	8
9	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	755,108	9	11,642		85,410	1,317	9
10	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	755,108	9	1,243,897	1,034,436	85,410	140,697	10
11	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	755,108	9	6,435		85,410	728	11
12	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	755,108	9	2,216		85,410	251	12
13	26	INSURANCE	AVAIL. CENSUS DAYS	755,108	9	4,598		85,410	520	13
14	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	755,108	9	272,029		85,410	30,769	14
15	30	DEPRECIATION	AVAIL. CENSUS DAYS	755,108	9	26,781		85,410	3,029	15
16	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	755,108	9	(7,220)		85,410	(817)	16
17	34	BUILDING RENT	AVAIL. CENSUS DAYS	755,108	9	105,808		85,410	11,968	17
18	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	755,108	9	67,754		85,410	7,664	18
19	39	ANCILLARY	AVAIL. CENSUS DAYS	755,108	9	(652)	(1,593)	85,410	(74)	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,974,446	$ 1,236,040		$ 223,329	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36	9	180,000	180,000	4	20,360	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	48	9	180,000	180,000	4	16,715	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	8	9	40,623	40,000	1	4,570	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	17	9	17,157	17,000	0	388	4
5										5
6	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36	9	15,944		4	1,803	6
7	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	48	9	8,574		4	796	7
8	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	8	9	3,170		1	357	8
9	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	17	9	1,411		0	32	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 446,879	$ 417,000		$ 45,021	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	339,037	13	$ 263,221	$ 263,221	9,975	$ 7,744	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	339,037	13	1,730		9,975	51	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	339,037	13	(3,296)		9,975	(97)	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	339,037	13	24,604		9,975	724	4
5	24	SEMINARS	CARE PATH FEES	339,037	13	784		9,975	23	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	339,037	13	57,412		9,975	1,689	6
7	32	INTEREST EXPENSE	CARE PATH FEES	339,037	13	(286)		9,975	(8)	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 344,169	$ 263,221		$ 10,126	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DIAMOND INSURANCE
Street Address: 40 SKOKIE BLVD SUITE 105
City / State / Zip Code: NORTHBROOK, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	WORKMANS COMP	DIRECT ALLOC			$	$		$ 67,360	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 67,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Jackson Square Associates		X				$	$			$ 825,312	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Shareholders	X			Interest Only			500,000	07/01			6
7									Annual		38,030	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 500,000			$ 863,342	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(10)	11
12	Allocated from NuCare										(817)	12
13	See Supplemental Schedule										(1,137)	13
14	TOTAL Non-Facility Related						$	$			$ (1,964)	14
15	TOTALS (line 9+line14)						$	$ 500,000			$ 861,378	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15	Interest Income Jackson Assoc.						$	$			$ (1,137)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(1,137)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	347,651	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	334,808	2
3. Under or (over) accrual (line 2 minus line 1).	$	(12,843)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	351,549	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	338,706	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	327,354	8
	1999	325,157	9
	2000	322,703	10
	2001	331,096	11
	2002	334,808	12

Accrual: $334,808x1.05=351,548

Less Prepayment of 3/03 Installment - $167,404

Clinic Allocation -$334,808*7.5%=$25,110.60

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nrsg & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-16-209-002-0000	Long Term Care Propery	$ 334,808.29	$ 309,697.69
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 334,808.29	$ 309,697.69

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jackson Square Nrsg & Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039834

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior Brick Frame Brick/Concrete Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medical Clinic - Costs are not included on Page 3 or 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	89,364	1987	$ 71,619	1
2					2
3	TOTALS	89,364		$ 71,619	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	198,972		20	9,949	9,949	29,846	9
10	Various			1988	17,097		20	854	854	2,564	10
11	Various			1989	19,023		20	952	952	2,854	11
12	Various			1990	33,869		20	1,693	(1,693)	5,080	12
13	Various			1991	10,518		20	526	526	1,578	13
14	Various			1993	3,315		20	166	166	497	14
15	Various			1994	110,244		20	5,512	5,512	18,547	15
16	Various			1995	57,890		20	2,896	2,896	24,688	16
17	Various			1996	131,988		20	6,601	6,601	49,435	17
18	Various			1997	126,299		20	6,411	6,411	40,703	18
19	Various			1998	35,115		20	1,756	1,756	9,708	19
20	Various			1999	67,125		20	3,359	3,359	15,106	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		3,173,042			95,250	95,250	1,524,417	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		2,695	108		135	27	606	68
69	Financial Statement Depreciation			78,038			(78,038)		69
70	TOTAL (lines 4 thru 69)		$ 3,987,192	$ 78,146		$ 136,060	$ 54,528	$ 1,725,629	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,987,192	$ 78,146		$ 136,060	$ 57,914	$ 1,725,629	1
2	Repair Door Lock Rep	2000	610		20	31	31	123	2
3	Frt - Install Icu	2000	1,700		20	85	85	340	3
4	Install 78 Over Bd L	2000	13,820		20	691	691	2,706	4
5	3Rd Flr Nursing Stat	2000	11,600		20	580	580	2,272	5
6	Wrought Iron Fence	2000	1,065		20	53	53	209	6
7	Install Cctv Monitor	2000	3,372		20	169	169	661	7
8	Install 1-600 Tank	2000	28,500		20	1,425	1,425	5,581	8
9	Install Voltage Coil	2000	945		20	47	47	154	9
10	Hook Ups Dialysis Ma	2000	24,200		20	1,210	1,210	4,638	10
11	Install Window Treat	2000	75		20	4	4	14	11
12	3' Brass Overbed Lig	2000	5,786		20	289	289	1,109	12
13	Repair Ballasts An	2000	906		20	45	45	174	13
14	Chiller Parts	2000	4,050		20	203	203	777	14
15	Ceiling Tiles	2000	846		20	42	42	162	15
16	Ceiling Tiles	2000	628		20	31	31	120	16
17	Furnish And Installs	2000	2,024		20	101	101	387	17
18	Generator Battery	2000	1,348		20	67	67	252	18
19	Furnish And Install	2000	896		20	45	45	169	19
20	Enclose 2 Smoking Lg	2000	26,130		20	1,307	1,307	4,900	20
21	Install Remote Multi	2000	1,672		20	84	84	314	21
22	Install Phone Lines	2000			20				22
23	Start Up Replacemnt	2000	252		20	13	13	48	23
24	Wall Paper & Border	2000	1,204		20	60	60	220	24
25	Repair Remote Wiring	2000	4,157		20	208	208	763	25
26	2 Motor Systems	2000	174		20	9	9	32	26
27	Rekey Dietary Dept	2000	1,387		20	69	69	254	27
28	Cableing For Compute	2000	686		20	34	34	123	28
29	Boiler Repairs	2000	7,300		20	365	365	1,338	29
30	Safety Slide Rails	2000	3,371		20	169	169	619	30
31	Furnish & Install	2000	735		20	37	37	133	31
32	Furnish & Install	2000	686		20	34	34	123	32
33	Carpeting	2000	2,949		20	147	147	503	33
34	TOTAL (lines 1 thru 33)		$ 4,140,266	$ 78,146		$ 143,714	$ 65,568	$ 1,754,847	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,140,266	$ 78,146		$ 143,714	$ 65,568	$ 1,754,847	1
2	Vents	2000	1,284		20	64	64	219	2
3	Faucet & Repair Kit	2000	697		20	35	35	120	3
4	Repair Compressor	2000	3,730		20	187	187	638	4
5	Floresent Lightin	2000	967		20	48	48	161	5
6	Adjust Control Panel	2000	526		20	26	26	96	6
7	Install Electric Doo	2000	1,635		20	82	82	273	7
8	Ran Phone Lines	2000	869		20	43	43	144	8
9	Fire Dampers For Ven	2000	5,350		20	268	268	848	9
10	Service Pa System	2000	1,160		20	58	58	184	10
11	Install Cctv & Vcr	2000	1,965		20	98	98	311	11
12	Ceiling Tiles	2000	694		20	35	35	110	12
13	Linen Chutes Door	2000	520		20	26	26	80	13
14	Light Fixture Covers	2000	826		20	41	41	127	14
15	Ceiling Tile	2000	715		20	36	36	111	15
16	Install Contracto	2000	2,970		20	149	149	471	16
17	Tank Removal	2000	2,914		20	146	146	583	17
18	Painting/Decorating	2000	2,601		20	130	130	401	18
19	Fire Dampers	2001	867		20	43	43	126	19
20	Generator Repair	2001	1,136		20	57	57	166	20
21	Security System Upgr	2001	956		20	48	48	136	21
22	Magnetic Door Holder	2001	975		20	49	49	139	22
23	Elevator Contrlr Unt	2001	2,000		20	100	100	275	23
24	Magnetic Door Holder	2001	952		20	48	48	127	24
25	Phone Line Installat	2001	994		20	50	50	132	25
26	Elevator Reapir	2001	742		20	37	37	96	26
27	Exit Signs	2001	547		20	27	27	71	27
28	Myers Pump	2001	1,261		20	63	63	158	28
29	Elevator Contrlr Unt	2001	2,598		20	130	130	314	29
30	Security Upgrades	2001	4,359		20	218	218	545	30
31	Light Fixtures	2001	2,223		20	111	111	268	31
32	Door Locks	2001	728		20	36	36	85	32
33	Magnetic Door Holder	2001	1,424		20	71	71	154	33
34	TOTAL (lines 1 thru 33)		$ 4,191,451	$ 78,146		$ 146,274	$ 68,128	$ 1,762,516	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,191,451	$ 78,146		$ 146,274	$ 68,128	$ 1,762,516	1
2	Exit Signs	2001	613		20	31	31	66	2
3	Exit Signs	2001	721		20	36	36	78	3
4	Door Locks	2001	1,646		20	82	82	220	4
5	Replace Boiler	2002	3,975		20	397	397	795	5
6	Exit Signs On 3Rd And 4Th Fl.	2002	1,537		20	154	154	307	6
7	Closed Circuit Tv System	2002	1,407		20	141	141	281	7
8	Alarm System (Serv/Upgrade)	2002	1,358		20	136	136	272	8
9	Install Magenetic Door Holders	2002	1,424		20	142	142	261	9
10	Install Closed Circ. Tv Sys.	2002	1,418		20	142	142	260	10
11	Install Alarm System	2002	1,334		20	133	133	211	11
12	Closed Circuit Tv System	2002	4,186		20	419	419	663	12
13	Installed Glass And Skylight	2002	1,795		20	180	180	299	13
14	115 Volt Fan	2002	980		20	98	98	139	14
15	Inside Awnings	2002	1,117		20	112	112	149	15
16	Awning For Back Door/Patio	2002	2,025		20	203	203	270	16
17	Landscaping	2002	14,800		20	1,480	1,480	1,973	17
18	Cctv System	2002	2,858		20	286	286	405	18
19	Cctv System	2002	1,953		20	195	195	277	19
20	Cctv System	2002	1,706		20	171	171	227	20
21	Supplies To Install Overbed Lights	2002	914		20	91	91	114	21
22	Cctv System Recorder	2002	1,410		20	141	141	176	22
23	78 Overbed Light Fixtures	2002	5,616		20	562	562	702	23
24	Installed Elctromagnet Door Holders	2002	1,446		20	145	145	169	24
25	Service On Cctv	2002	1,298		20	130	130	151	25
26	Additional Trip Charges	2002	2,300		20	230	230	307	26
27	20 Overbed Light Fixtures	2002	1,440		20	144	144	156	27
28	Service On Cctv	2002	1,106		20	111	111	221	28
29	Service On Cctv	2002	910		20	91	91	182	29
30	Resurface Parking Lot/Sidewalk	2002	34,263		20	1,713	1,713	3,426	30
31	Outdoor Signs	2003	6,000		20	600	600	600	31
32	Outdoor Signs	2003	11,627		20	1,163	1,163	1,163	32
33	Cctv	2003	1,684		20	126	126	126	33
34	TOTAL (lines 1 thru 33)		$ 4,308,318	$ 78,146		$ 156,059	$ 77,913	$ 1,777,162	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,308,318	$ 78,146		$ 156,059	$ 77,913	$ 1,777,162	1
2	Dr Alarm	2003	886		20	95	95	95	2
3	Tel Lines	2003	1,064		20	80	80	80	3
4	Computer	2003	1,756		20	117	117	117	4
5	Elevator Repair	2003	6,276		20	209	209	209	5
6	Wall Paper	2003	1,008		20	672	672	672	6
7	Tel Lines	2003	999		20	58	58	58	7
8	Tel Lines	2003	873		20	51	51	51	8
9	Fire Alarm	2003	858		20	72	72	72	9
10	Tel Lines	2003	1,075		20	63	63	63	10
11	Install Tel	2003	629		20	37	37	37	11
12	Install Telephone	2003	977		20	57	57	57	12
13	Drapery	2003	1,586		20	106	106	106	13
14	Conc Drive	2003	14,371		20	838	838	838	14
15	Land Improvement	2003	740		20	25	25	25	15
16	Limestone Planters	2003	5,960		20	232	232	232	16
17	Landscape	2003	2,291		20	76	76	76	17
18	Carpet	2003	2,414		20	115	115	115	18
19	New Sign	2003	999		20	17	17	17	19
20	Window Treatment	2003	399		20	10	10	10	20
21	Lights	2003	1,522		20	25	25	25	21
22	Vinal Tile	2003	739		20	4	4	4	22
23	Fire Alarm	2003	1,196		20	28	28	28	23
24	Woodwork Remodeling	2003	23,200		20	2,320	2,320	2,320	24
25	Nurse Station	2003	9,500		20	475	475	475	25
26	Medical Room	2003	2,900		20	145	145	145	26
27	Medical Room-Fl4	2003	2,900		20	145	145	145	27
28	Safety Lock System	2003	405		20	20	20	20	28
29	Locksets	2003	1,073		20	54	54	54	29
30	Locksets	2003	233		20	12	12	12	30
31	Waste Water Disposal Sys	2003	1,569		20	78	78	78	31
32	Glass Installation	2003	705		20	35	35	35	32
33	Locks	2003	769		20	38	38	38	33
34	TOTAL (lines 1 thru 33)		$ 4,400,190	$ 78,146		$ 162,369	$ 84,223	$ 1,783,472	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,400,190	$ 78,146		$ 162,369	$ 84,223	$ 1,783,472	1
2	Toilets	2003	531		20	27	27	27	2
3	Faucets	2003	519		20	26	26	26	3
4	Boiler Repairs	2003	1,088		20	54	54	54	4
5	Motor	2003	710		20	36	36	36	5
6	Pump Motor	2003	824		20	41	41	41	6
7	Elevator Repairs	2003	534		20	27	27	27	7
8	Corner Guards	2003	527		20	26	26	26	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,404,923	$ 78,146		$ 162,606	$ 84,460	$ 1,783,708	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1987	1980	$ 3,173,042	$		$ 95,250	$ 95,250	$ 1,524,417	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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54									54
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,173,042	$		$ 95,250	$ 95,250	$ 1,524,417	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	NuCare Allocation			1997	521	13	35	26	13	162	10
11	NuCare Allocation			1998	456	12	35	23	11	125	11
12	NuCare Allocation			1999	640	55	35	32	23	142	12
13	NuCare Allocation			2000	777	20	35	39	19	134	13
14	NuCare Allocation			2001	301	8	35	15	7	43	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,695	$ 108		$ 135	$ 73	$ 606	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 696,112	$ 54,038	$ 81,099	$ 27,061	10	$ 322,066	71
72	Current Year Purchases	36,228	14,139	3	(14,136)	10	3	72
73	Fully Depreciated Assets	26,115	142	142		10	26,115	73
74								74
75	TOTALS	$ 758,455	$ 68,319	$ 81,244	$ 12,925		$ 348,184	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1992 FORD VAN	1990	$ 2,282	$	$	$	5	$	76
77										77
78										78
79										79
80	TOTALS			$ 2,282	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,237,279	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 146,465	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,849	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 97,384	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,131,892	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	INSTALL NEW COMPRESS - 2000	$ 16,764	$ 1,118	$	86
87	WATER FAUCETS - 2001	1,361	136		87
88	RESURFACE PARKING LOT/SIDEWA	2,778			88
89					89
90					90
91	TOTALS	$ 20,903	$ 1,254	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated to NuCare				11,968			5
6								6
7	TOTAL				$ 11,968 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,272 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Business	2001 Lexus RX300	$ 593.00	$ 7,116	17
18					18
19					19
20					20
21	TOTAL		$ 593.00	$ 7,116	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 163,929	$		$ 163,929	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			49,488			49,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			95,883			95,883	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			176,355	21,482		197,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			12,184			112,741		124,925	13
14	TOTAL			$ 12,184		$ 485,655	$ 134,223		$ 632,062	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,386	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,824,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	149,096		6
7	Other Prepaid Expenses	13,924		7
8	Accounts Receivable (owners or related parties)	733,071		8
9	Other(specify): See Attached Schedule	178,037		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,901,098	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	880,015		15
16	Equipment, at Historical Cost	647,921		16
17	Accumulated Depreciation (book methods)	(821,606)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	54,080		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 760,410	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,661,508	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 783,003	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,444		28
29	Short-Term Notes Payable	500,000		29
30	Accrued Salaries Payable	235,204		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,755		31
32	Accrued Real Estate Taxes(Sch.IX-B)	351,549		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,436		35
	Other Current Liabilities(specify):			
36	See Attached Schedule	175,098		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,079,489	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,079,489	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,582,019	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,661,508	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,786,958	1
2	Restatements (describe):		2
3	**Restatements (see attached schedule)**	11,310	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,798,268	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(216,249)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (216,249)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,582,019	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,642,100	1
2	Discounts and Allowances for all Levels	(378,411)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,263,689	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	740,581	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 740,581	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	107,500	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,522	19
20	Radiology and X-Ray	2,890	20
21	Other Medical Services	350,678	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 502,590	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,506,870	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,691,498	31
32	Health Care	3,064,546	32
33	General Administration	2,123,024	33
	B. Capital Expense		
34	Ownership	2,031,113	34
	C. Ancillary Expense		
35	Special Cost Centers	684,823	35
36	Provider Participation Fee	128,115	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,723,119	40
41	**Income before Income Taxes (line 30 minus line 40)****	(216,249)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (216,249)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,951	2,151	$ 78,996	$ 36.73	1
2	Assistant Director of Nursing	1,885	2,186	62,060	28.39	2
3	Registered Nurses	12,627	14,057	484,921	34.50	3
4	Licensed Practical Nurses	42,405	46,002	860,758	18.71	4
5	Nurse Aides & Orderlies	111,350	121,740	1,013,524	8.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	304	304	12,184	40.08	7
8	Rehab/Therapy Aides	5,821	6,372	91,494	14.36	8
9	Activity Director	2,789	3,214	39,155	12.18	9
10	Activity Assistants	5,088	5,670	49,827	8.79	10
11	Social Service Workers	3,600	4,054	79,637	19.64	11
12	Dietician	3,552	3,870	58,879	15.21	12
13	Food Service Supervisor					13
14	Head Cook	5,169	5,571	44,229	7.94	14
15	Cook Helpers/Assistants	21,123	23,028	167,639	7.28	15
16	Dishwashers					16
17	Maintenance Workers	6,963	6,963	91,216	13.10	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,960	2,086	86,956	41.69	20
21	Assistant Administrator					21
22	Other Administrative	927	927	51,832	55.91	22
23	Office Manager					23
24	Clerical	15,947	17,444	161,041	9.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,976	3,402	77,921	22.90	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,759	1,759	52,761	29.99	33
34	TOTAL (lines 1 - 33)	248,196	270,800	$ 3,565,030 *	$ 13.16	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	$ 20,764	01-03	35
36	Medical Director	Monthly Fee	21,600	09-03	36
37	Medical Records Consultant	Monthly Fee	4,128	10-03	37
38	Nurse Consultant	Monthly Fee	1,140	10-03	38
39	Pharmacist Consultant	Monthly Fee	4,212	10-03	39
40	Physical Therapy Consultant	92	4,201	10a-03	40
41	Occupational Therapy Consultant	123	5,315	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,504	11-03	44
45	Social Service Consultant	51	2,716	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	314	$ 66,580		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 360	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8	$ 360		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wayne Hanik (01/01/03-11/18/03)	Administrator	0	$ 77,436
Brian Celerio (11/18/03-12/31/03)	Administrator	0	9,520
Kathy Brander	Dir of Regulatory Mgmt	0	11,795
Ray Dolan	VP of Risk Mgmt	0	4,030
Rusti Bauman	VP of Medicare Reimb	0	1,674
Marilyn Flaherty	VP of Medicare Reimb	0	2,227
See Supplemetal Schedule			32,106
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 138,788

B. Administrative - Other

Description	Amount
NuCare Service - Management Fees	$ 617,340
Carepath Health Network	9,975
TOTAL (agree to Schedule V, line 17, col. 3)	$ 627,315

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 1,779
Stone McGuire Benjamin	Legal	19,798
Myers Miller Standa	Legal	1,346
Morgan Lewis	Legal	53
Sahnoff & Weaver, LTD	Legal	1,043
Kimberly Weissman	Legal	3,206
Schwartz Cooper	Legal	476
Frost Ruttenberg & Rothblatt	Accounting	27,929
Daniel Foley, CPA	Accounting	200
Professional Planners Inc	Unemploy Consulting	2,181
CDW Computer Center	Computer Services	410
See Supplemetal Schedule		21,039
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 79,459

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,360
Unemployment Compensation Insurance	38,522
FICA Taxes	267,636
Employee Health Insurance	82,865
Employee Meals	17,706
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	6,492
Union Health Insurance	61,862
Union Pension Benefits	28,753
Other Employee Benefits	13,914
401K Plan	4,100
TOTAL (agree to Schedule V, line 22, col.8)	$ 589,210

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,486
Health Care Worker Background Check	1,090
(Indicate # of checks performed 45)	
Dues & Subscriptions	10,145
Licenses & Fees	2,978
Allocation Nucare	1,317
Allocation Carepath	(97)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,919

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,870
Allocation NuCare	728
Allocation Carepath	23
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,621

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Jackson Square Nrsg & Rehab # 0039834 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $12,671.12**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,977** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **128,115**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,706** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%In14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.